AGING AND DISABILITY SERVICES ADMINISTRATION

PARTICIPATION REIMBURSEMENT FORM

CLIENT NAME	CASE NUMBER	DATE

SERVICE WORKER INFORMATION

AUTHORIZING SERVICE WORKER (PRINT)	TELEPHONE NUMBER

MAILING ADDRESS

AUTHORIZING SERVICE WORKER'S SIGNATURE	REPORTING UNIT

REIMBURSEMENT COMPUTATION FORMAT

COLUMN A	COLUMN B	COLUMN C	COLUMN D
SSPS Service Code and Month/Year Services Were Authorized	Wrongfully Paid Participation Amount (Actual Payment has been Verified)	Financial Services Retroactively Corrected Participation Amount	Subtract Column C from Column B, Enter Remainder Below
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
COLUMN TOTALS			

Column B Minus Column C = Total Reimbursement Amount

Reimbursement Method:

☐ Participation adjustment/suspension for _____ (month/year) and _____ (month/year)

☐ Recipient "reimbursement packet" forwarded COPES/MPC Program Manager, Olympia, MS 45600 on _____ (month/day/year)

SUPERVISOR'S REVIEW AND APPROVAL (SIGNATURE)	DATE

DSHS 07-081 (02/2003)